

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(l) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

#### 4.5 Basis of Property, Plant and Equipment

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

- (1) purchase price,
- (2) sales tax,
- (3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the

productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset or group of assets that has a basis of \$500 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

#### 4.6 Depreciation and Amortization of Property, Plant and Equipment

(a) Costs for depreciation and amortization must be based on property records sufficient in detail to identify specific assets.

(b) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

#### 4.7 Change in Ownership of Depreciable Assets - Sales of Facilities

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transac-

tions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire

twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lowest of:

- (i) the fair market value of the assets,
- (ii) the acquisition cost of the asset to the buyer,
- (iii) the original basis of the asset to the seller as recognized by the Division, less accumulated depreciation, plus the amount of depreciation recaptured from the seller.

(2) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred real property and fixed assets for the new owner shall be the lowest of:

- (i) the fair market value of the assets,
- (ii) the acquisition cost of the asset to the buyer,
- (iii) the amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by the Division, by an annual percentage rate. The annual percentage rate will be limited to the lower of:

(A) One-half the percentage increase in the Consumer Price Index (CPI) for All Urban consumers (United States City Average).

(B) One-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index for the same period.

(3) After a change in ownership, the depreciation for moveable equipment and vehicles shall be based on the greater of the following :

- (i) the seller's allowable basis, with the continuation of the seller's allowable depreciation schedule, or
- (ii) an independent appraisal of the asset's value and a new estimate of the remaining useful life.

#### 4.8 Recapture of Depreciation

(a) The sale or transfer of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property to the owner of record as reduced by Medicaid allowable depreciation, resulting in a gain on sale or transfer, and in accordance with these regulations, indicates that depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made as part of the per diem rate for care of Medicaid residents shall be determined as follows.

(b) The gross recapture amount shall be the lesser of the actual gain on the sale, as computed above, or the amount of depreciation that was paid as part of the per diem rates by the state for the care of Medicaid residents to the owner of the facility.

(c) The depreciation to be recovered shall be calculated as follows:

(1) If the facility has been held by the seller for five years or less, an amount equal to the full depreciation paid as part of the per diem rates by the state for the care of Medicaid residents to the owner of the facility.

(2) If the facility has been held by the seller for more than five years, an amount equal to the full depreciation, paid as part of the per diem rates is subject to recovery, but the amount to be recovered shall be reduced by fourteen and one quarter percent for each year after the fifth year.

(d) Sixty days before the date of the closing or at such time as the terms of the sale are final (whichever is the later), the seller and the buyer shall jointly file with the Division the following documents:

(1) the purchase and sale agreement, schedules, disclosure statements, collateral agreements, and other documents which might help to determine the selling price for the facility,

(2) the most recent appraisals of all facilities and other properties or businesses whose ownership will change as a result of the same transaction,

(3) an estimate of the amount of depreciation recapture payable pursuant to this subsection or an explanation of the sellers' rationale for believing that no depreciation recapture is payable.

(4) a schedule for the closing of the transaction, which shall be subsequently updated to reflect any changes in the schedule.

(e) Within 20 days of the receipt of all these materials, the Division shall issue to the seller, with a copy to the buyer, a statement of net recapture overpayment amount setting out the amount of depreciation recapture payable or a statement that none is payable.

(i) The net recapture overpayment amount, if any, determined pursuant to Subparagraphs (1) and (2) above, shall be paid to the state by the seller at the time of closing. The Division's inability to issue a final statement of depreciation recapture before the closing date does not absolve the seller from its obligation to pay depreciation recapture at the time of closing. Interest at the legal rate shall be payable from that date on any unpaid balances. However, if sufficient cause can be shown, the seller may request additional payment time, the granting of which may require the execution of an escrow agreement with the state. Until such time as the requirements for depreciation recapture under this section have been satisfied, the amount not paid shall be deducted from

future payments by the state to the buyer until net recapture has been received.

(f) In cases where an owner-operator withdraws from the Medicaid program as a provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time she/he was a Medicaid provider shall be subject to the depreciation recapture provisions of these rules when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated licensed operator after having operated the facility as a licensed Medicaid provider.

#### 4.9 Leasing Arrangements for Property, Plant and Equipment

Leasing arrangements for property, plant and equipment must meet the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes incurred for the year under review, or the price of comparable services or facilities purchased elsewhere, whichever is lower.

(b) Rental or leasing charges, including sale and leaseback agreements for property, plant and equipment to be included in allowable costs cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

#### 4.10 Funding of Depreciation

(a) Funding of depreciation is not required, but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(b) To the extent that the provider fails to retain sufficient working capital or sufficient resources to support operations, before making deposits in a funded depreciation account, the deposits will not be recognized as funded depreciation.

(c) To the extent that funded depreciation in the cost reporting period under consideration is used for purposes other than nursing facility asset acquisition, interest income on those sums will be offset against interest expense not only in the current period, but the Division may reopen settled cost reports for previous periods to revise funded depreciation and allowable interest expense. However, with the prior approval of the Division, under appropriate conditions, some or all of a provider's funded depreciation may be used as follows without triggering an interest income offset:

(1) to convert existing nursing home beds to residential care or assisted living, or

(2) when more economic, for new construction of residential care or assisted living units with a reduction in licensed nursing home beds.

(d) All relevant provisions of HCFA-15 shall be followed, except as noted below:

(1) Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest will apply.

(2) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If the lessee is allowed to use this replacement reserve for

the replacement of the lessee's assets, lessee shall not be allowed to depreciate the assets purchased.

(e) The provider must maintain appropriate documentation to support the funded depreciation account and income earned thereon to be eligible for relief from the investment income offset.

#### 4.11 Large Asset Acquisitions

(a) A provider may apply to the Division for an adjustment to the property and related component of the rate for *individual* capital expenditures determined to be necessary and reasonable. No application for a rate adjustment should be made if the change to the rate would be smaller than one half of one percent of the facility's rate in effect at the time the application is made. Interest expense related to these assets, provided it is necessary and reasonable, shall be included in calculating the adjustment.

(b) Application shall also be made under this subsection, no later than 30 days after the execution of a purchase and sale or other binding contract, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to Subsection 4.7. The Division may make related adjustments to the Property and Related rate component.

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to this subsection is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in subsection 8.7(b), but are subject to the other provisions of subsection 8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required.

(d) In the event that approval is granted by the Division, the adjustment will be made effective from the first day of the quarter after the filing date of the written notice, following the date of the final order on the application, or following the date the asset is actually put into service, whichever is the latest.

**4.12 [Repealed]**

**4.13 Advertising Expenses**

The reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

**4.14 Barber and Beauty Service Costs**

The direct costs of barber and beauty services are not allowable for purposes of Medicaid reimbursement. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services are allowable.

**4.15 Bad Debt, Charity and Courtesy Allowances**

Bad debts, charity and courtesy allowances are deductions from revenues and are not to be included in allowable costs.

**4.16 Child Day Care**

Reasonable and necessary costs incurred for the provision of day care services to children of employees performing resident related functions will be allowable. Costs will be adjusted by any revenues received for the provision of care provided to employees' children. The direct and indirect expenses related to providing these services to non-employee children are not an allowable expense. Costs must be accumulated in a separate cost center. Revenues earned from providing day care must be identified for employees and non-employees in a separate account.

**4.17 Community Service Activities**

As an incentive for nursing home providers to furnish services (i.e., meals-on-wheels, respite care, etc.) to local not-for-profit organizations only direct identifiable incremental costs will be adjusted (i.e., food, direct labor and fringe benefits, transportation). Overhead costs will not be apportioned for adjustment unless there is a significant expansion to a program resulting from community service involvement. The provider must maintain auditable records for all incremental direct costs associated with providing a community service.

**4.18 Dental Services**

Costs incurred for services performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth will not be allowed for the purposes of calculating the per diem rate. Dental services for Medicaid eligible individuals are covered pursuant to the *Vermont Welfare Assistance Manual*. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services may be allowable.

**4.19 Legal Costs**

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

**4.20 Litigation and Settlement Costs**

**(a) Civil and criminal litigation -**

(1) General Rule. Attorney fees and other expenses incurred in conjunction with litigation will be recognized only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance.

(2) Settlements. In instances, where a matter is settled before judgment (whether or not a lawsuit has been commenced), one half the costs, including attorney fees, settlement award, and other expenses, relating to the matter will be recognized to

the extent that the costs are related to resident care and are not covered by insurance.

(3) Costs related to criminal or professional practice matters are not allowable.

(b) Challenges to decisions of the Division - Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined on the ratio of total dollars at issue in the case to the total dollars awarded to the provider, subject to the non-recurring costs provision, subsection 4.3(a)(2).

#### 4.21 Motor Vehicle Allowance

Cost of operation of a motor vehicle necessary to meet the facility needs is an allowable cost. Where the vehicle is used for personal and business purposes, the portion of vehicle costs associated with personal use will not be allowed. If the provider does not document personal use and business use under a pre-approved method, DRS reserves the right to disallow all vehicle costs in question. All costs in excess of the cost of a similar size mid-price vehicle are not allowable.

#### 4.22 Non-Competition Agreement Costs

Amounts paid to the seller of an on-going facility by the purchaser for an agreement not to compete are considered capital expenditures. The amortized costs for such agreements are not allowable.

#### 4.23 Compensation of Owners, Operators, or their Relatives

(a) Facilities which have a full-time (40 hours per week minimum) administrator and/or assistant administrator, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in limited and special circumstances such as those listed in paragraph (b) of this subsection.

(b) The factors to be evaluated by the Division in determining the amount allowable for owner's compensation shall include, but not limited to the following:

(1) All applicable Medicare policies identified in HCFA-15.

(2) The unduplicated functions actually performed, as described by the provider on the Medicaid cost report.

(3) The hours actually worked and the number of employees supervised, as reported on the cost report.

(c) The maximum allowable salary for an owner administrator shall be equal to 110 percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program as increased to the current cost reporting period by the wages and salaries portion of the DRI-NHMB.

#### 4.24 Management Fees and Home Office Costs

(a) Management fees, home office costs and other costs incurred by a nursing facility for similar services provided by other entities shall be included in the Indirect Cost category. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and shall include property and related costs incurred for the management company. These costs are allowable only if such costs would be allowable if a nursing facility provided the services for itself.

(b) Allowable costs shall be limited to five percent of the total net allowable costs less reported management fees, home office, or other costs, as defined in this subsection.

#### 4.25 Membership Dues

Reasonable and necessary membership dues, including any portions used for lobbying activities, shall be considered Medicaid allowable costs, provided the organization's func-

tion and purpose are directly related to providing resident care.

#### 4.26 Post-Retirement Benefits

Certain benefits which may be available to retired personnel are not required to be accrued in accordance with Generally Accepted Accounting Principles. If it should be determined by the FASB or other authoritative body that such post retirement benefits must be accrued, the Division will not allow costs of such benefits that exceed actual cost paid.

#### 4.27 Public Relations

Costs incurred for services, activities and events that are determined by the Division to be for public relations purposes will not be allowed.

#### 4.28 Related Party

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

#### 4.29. Revenues

Where a facility reports operating and non-operating revenues related to goods or services, the costs to which the revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than such costs, the deduction shall be equal to such costs.

#### 4.30 Travel/Entertainment Costs

Only reasonable and necessary costs of meals, lodging, transportation and incidentals incurred

for purposes related to resident care will be allowed. All costs determined to be for the pleasure and convenience of the provider or providers' representatives will not be allowed.

#### 4.31 Transportation Costs

Costs of transportation incurred, other than ambulance services covered pursuant to the *Vermont Welfare Assistance Manual*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

#### 4.32 Services Directly Billable

Allowable costs shall not include the cost of services to individual residents which are ordinarily billable directly to Medicaid irrespective of whether such costs are payable by Medicaid.

### 5 REIMBURSEMENT STANDARDS

#### 5.1 Prospective Case-Mix Reimbursement System

(a) In general, these rules set out incentives to control costs and Medicaid outlays, while promoting access to services and quality of care.

(b) Case-mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection;

(2) a means to classify residents into groups which are similar in costs, known as VT 1992 RUGS-III (44 group version); and

(3) a weighting system which quantifies the relative costliness of caring for different

classes of residents to determine the average case-mix score.

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related costs from the most recently settled cost report, calculated as described in Subsection 9.6.

#### **5.2 Retroactive Adjustments to Prospective Rates**

(a) In general, a final rate may not be adjusted retroactively.

(b) The Division may retroactively revise a final rate under the following conditions:

(1) as an adjustment pursuant to Sections 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to Subsection 15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to Subsections 5.10, 8.3, and 10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 3.5;

(6) in those cases where a rate includes payment for Ancillary services and the provider subsequently arranges for another Medicaid provider to provide and bill directly for these services;

(7) recovery of overpayments, or other adjustments as required by law or duly promulgated regulation; or

(8) when revisions of final rates are necessary to pass the upper limits test in 42 C.F.R. §447.272.

#### **5.3 Lower of Rate or Charges**

(a) At no time shall a facility's Medicaid per diem rate exceed the provider's average customary charges to the general public for nursing facility services in semi-private rooms at the beginning of the calendar quarter. In this subsection, "charges" shall mean the amount actually required to be paid by or on behalf of a resident (other than by Medicaid, Medicare Part A or the Department of Veterans Affairs) and shall take into account any discounts or contractual allowances.

(b) It is the duty of the provider to notify the Division within 10 days of the beginning of each calendar quarter of any change in its charges.

#### **5.4 Interim Rates**

(a) The Division may set interim rates for any or all facilities. The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to any provision of these rules or 33 V.S.A. §909.

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

#### **5.5 Upper Payment Limits**

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272, using Medicare principles of reimbursement.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

#### **5.6 Base Year**

(a) A Base Year shall be a calendar year, January through December.

(b) The Director shall determine the frequency of rebasing and shall select the Base Year. However, rebasing for nursing care costs shall occur no less frequently than once every three years and for other costs no less frequently than once every four years, unless the Secretary, on the advice of the Director, certifies to the General Assembly that rebasing is unnecessary.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

## 5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used for the purpose of calculating per diem costs.

(c) The 90 percent minimum occupancy provision shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10.

## 5.8 Inflation Factors

The Director shall determine the specific publication of each index used in the calculation of inflation factors. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example,

if an average cost in the Nursing Care Cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the DRI-NHMB, and the employee benefits portion of the DRI-NHMB, respectively.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses five price indexes to account for estimated economic trends with respect to five subcomponents of Resident Care costs: wages and salaries, employee benefits, food, utilities and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the DRI-NHMB, the employee benefits portion of the DRI-NHMB, the food at home portion of the NECPI-U, the commercial power portion of the NECPI-U and the NECPI-U (all items), respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the DRI-NHMB, the employee benefits portion of the DRI-NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price

indexes for each subcomponent are: the wages and salaries portion of the DRI-NHMB, and the employee benefits portion of the DRI-NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

#### 5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to 90 percent occupancy of all beds used or intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in Sections 4, 7 and subsection 9.1(g) shall apply.

(b) The costs reported in the budget cost report shall not exceed reasonable budget projections (adjusted for inflation and changes in interest rates as necessary) submitted in connection with the Certificate of Need.

(c) Property and related costs included in the rate shall be consistent with the property and related costs in the approved Certificate of Need.

(d) A revision may be made to the prospective case-mix rate based on a "look-back" which will be computed based on a provider's actual allowable costs.

#### 5.10 Costs for Terminating Facilities

(a) When a nursing facility plans to discontinue all or part of its operation, the Division may adjust its rate so as to ensure the protection of the residents of the facility.

(b) A facility applying for an adjustment to its rate pursuant to this subsection must have a

transfer plan approved by the Department of Aging and Disabilities, a copy of which shall be supplied to the Division.

(c) An application under this subsection shall be made on a form prescribed by the Director and shall be accompanied by a financial plan demonstrating how the provider will meet its obligations set out in the approved transfer plan.

(d) In approving such an application the Division may waive the minimum occupancy requirements in Subsection 5.7, the limitations on costs in Section 7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this subsection shall remain in effect for a period not to exceed six months.

### 6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

#### 6.1 General

In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. The Base Year costs shall be grouped into the following cost categories:

#### 6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual personnel costs for providing direct resident care, which are required to meet federal and state laws. The following are examples of nursing costs:

- (1) registered nurses,
- (2) licensed practical nurses,
- (3) nurse aides, including wages related to initial and on-going nurse aide training as required by OBRA,
- (4) contract nursing,
- (5) fringe benefits, including child day care.

(b) Costs of ward clerks, medical records and librarians will not be considered nursing costs.

The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

### 6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

- (a) food, vitamins and food supplements,
- (b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
- (c) activities personnel, including recreational therapy and direct activity supplies,
- (d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
- (e) counseling personnel, chaplains, art therapists and volunteer stipends,
- (f) social service worker
- (g) employee physicals,
- (h) medical supplies not charged and non-legend drugs not charged that meet the following criteria:

- (1) It is a medical supply or non-legend drug which is furnished routinely and relatively uniformly to all residents and for which no separate charge is recorded.
- (2) It is a supply or drug which does not require a doctor's prescription under federal or state law.
- (3) Costs for the supply or drug are not billed directly to any governmental unit.

- (i) incontinent supplies, including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc., and
- (j) fringe benefits, including child day care,
- (k) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

### 6.4 Indirect Costs

- (a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from

a facility's cost report or the cost report of an affiliated hospital or institution.

- (1) fiscal services,
- (2) administrative services and professional fees,
- (3) plant operation and maintenance
- (4) grounds,
- (5) security,
- (6) laundry and linen,
- (7) housekeeping,
- (8) medical records,
- (9) cafeteria,
- (10) all employee education, except nurse aide wages related to initial and on-going nurse aide training as required by OBRA,
- (11) dietary excluding food,
- (12) motor vehicle,
- (13) clerical, including ward clerks,
- (14) transportation (excluding depreciation).
- (15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
- (16) office supplies/telephone,
- (17) conventions and meetings,
- (18) EDP bookkeeping/payroll,
- (19) fringe benefits including child day care.

- (b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure.

### 6.5 Director of Nursing

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

## 6.6 Property and Related

The following are Property and Related costs:

- (a) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and amortization of leasehold improvements and capital leases,
- (b) interest on capital indebtedness,
- (c) real estate leases and rents,
- (d) real estate/property taxes,
- (e) equipment rental,
- (f) fire and casualty insurance,
- (g) amortization of mortgage acquisition costs.

## 6.7 Ancillaries

Ancillary services include, but are not limited to non-legend drugs charged, medical supplies-charged, physical therapy, speech therapy, occupational therapy and, respiratory therapy, including the costs of oxygen. Therapy services should be classified as ancillaries whether or not the provider customarily records separate charges for these services. Overhead costs related to ancillary services and supplies are included in ancillary costs.

## 7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

### 7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care cost category, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

### 7.2 Nursing Care Component

#### (a) Case-Mix Weights.

- (1) There are 44 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Class No.	RUG	Case-Mix Weight	Description
1	RVC	2.0158	Rehabilitation Very High Intensity C
2	RVB	1.4803	Rehabilitation Very High Intensity B
3	RVA	1.3129	Rehabilitation Very High Intensity A
4	RHD	1.8738	Rehabilitation High Intensity D
5	RHC	1.4959	Rehabilitation High Intensity C
6	RHB	1.3746	Rehabilitation High Intensity B
7	RHA	1.2441	Rehabilitation High Intensity A
8	RMC	1.7503	Rehabilitation Medium Intensity C
9	RMB	1.3120	Rehabilitation Medium Intensity B
10	RMA	1.2336	Rehabilitation Medium Intensity A
11	RLB	1.2371	Rehabilitation Low Intensity B
12	RLA	1.1028	Rehabilitation Low Intensity A
13	SE3	3.7496	Extensive Services 3
14	SE2	2.2493	Extensive Services 2
15	SE1	1.5423	Extensive Services 1
16	SSC	1.4054	Special Care C
17	SSB	1.2600	Special Care B
18	SSA	1.1740	Special Care A
19	CD2	1.2334	Clinically Complex D with Depression
20	CD1	1.2002	Clinically Complex D w/o Depression
21	CC2	1.0846	Clinically Complex C with Depression
22	CC1	1.0246	Clinically Complex C w/o Depression
23	CB2	1.0286	Clinically Complex B with Depression
24	CB1	0.9094	Clinically Complex B w/o Depression
25	CA2	0.8834	Clinically Complex A with Depression
26	CA1	0.7337	Clinically Complex A w/o Depression
27	IB2	0.9275	Impaired Cognition B- 2 NSG Rehab
28	IB1	0.8341	Impaired Cognition B
29	IA2	0.7274	Impaired Cognition A- 2 NSG Rehab
30	IA1	0.6283	Impaired Cognition A
31	BB2	0.9283	Challenging Behavior B - 2 NSG Rehab
32	BB1	0.8195	Challenging Behavior B
33	BA2	0.6560	Challenging Behavior A- 2 NSG Rehab
34	BA1	0.5590	Challenging Behavior A
35	PE2	1.0347	Reduced Physical Functioning E 2
36	PE1	0.9925	Reduced Physical Functioning E 1
37	PD2	0.9723	Reduced Physical Functioning D 2
38	PD1	0.9122	Reduced Physical Functioning D 1
39	PC2	0.8327	Reduced Physical Functioning C 2
40	PC1	0.8156	Reduced Physical Functioning C 1
41	PB2	0.7316	Reduced Physical Functioning B 2

42	PB1	0.6536	Reduced Physical Functioning B 1
43	PA2	0.6279	Reduced Physical Functioning A 2
44	PA1	0.5149	Reduced Physical Functioning A 1

(2) For residents certified by the Division of Licensing and Protection to have Atypically Severe Challenging Behaviors, the case-mix weight shall be 1.843.

(b) Average case-mix score

The Department of Aging and Disabilities' Division of Licensing and Protection shall compute each facility's average case-mix score .

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point.

Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Limits on Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(2) The limit on per diem Nursing Care costs per case-mix point shall be the median plus 15 percent.

(3) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (2) or the facility's Nursing Care cost per case-mix point. Once all facilities' reported costs are final, this limit will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors.

### 7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.